CHAPTER 7

SYSTEM ACCOUNTABILITY AND OVERSIGHT

CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

California's public mental health system provides mental health services to persons with serious mental illnesses who have no recourse to services in the private health care sector. Most public mental health clients, through either poverty or the degree of disability caused by their mental illness, qualify for Medi-Cal and receive public services through that funding source. Annually, the mental health system serves over 360,000 clients as shown in Table 6 below. Approximately three-fourths of the clients are adults, and one-quarter are children. Approximately 1 percent of the State's population received services from the public mental health system in fiscal year 1996-97.

Table 6 classifies clients according to the type of services they receive. Brief services are a modality in which a client receives services for a limited time, usually less than 60 days, to resolve a situational problem, such as grief from a loss, minor depression, or anxiety from family disputes. Long-term services are provided to adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) who have persistent mental health problems requiring services for a period longer than 60 days.

Table 6: Clients Served by the Public Mental Health System in Fiscal Year 1996-97

Client Type	Children (0-17)	Adults (18+)	Total
Brief Services	71,900	80,700	152,600
SMI/SED (long-term)	24,400	184,300	208,700
Total	96,300	265,000	361,300
State Population	9,456,000	24,408,000	33,364,000

Table 7, which provides the breakdown of clients' diagnoses for fiscal year 1994-95, reveals the serious nature of the mental illnesses treated by the mental health system. Schizophrenia and other psychoses comprise 25 percent of the diagnoses; bipolar disorder, 8 percent; and depressive disorders, 22 percent. These disorders typically require life-long management, frequently with the continuous use of medications. The diagnoses of children in the mental health system are typically childhood disorders and adjustment disorders, which together account for approximately 20 percent of the diagnoses.

Table 7: Diagnoses of Clients in the Public Mental Health System in Fiscal Year 1994-95

Diagnosis	Percent
Schizophrenia	13.2
Other Psychoses	11.5
Bipolar Disorder	7.9
Depressive Disorders	22.3
Substance Abuse	5.8
Other Nonpsychotic	9.8
Childhood Disorders	9.7
Adjustment Disorders	10.7
Cognitive Disorders	1.5
Unknown	7.6

Because of the ethnic diversity in California, the public mental health system must meet the needs of a very diverse population. As Table 8 illustrates, over half the clients served in the mental health system in fiscal year 1996-97 were White; nearly 19 percent, Hispanic; 16 percent, African American; and approximately 6 percent from various Asian ethnic groups. Because the concept of mental illness and traditional treatments vary among cultures, providing culturally competent services to clients of such diverse ethnic backgrounds is a major challenge for the mental health system. Even more difficult is meeting the needs of monolingual clients.

DRAFT

Table 8: Ethnicity of Clients in the Public Mental Health System in Fiscal Year 1996-97

Race	Percent
White	53.7
Hispanic	18.7
African American	16.0
Native American	0.9
Asian/Pacific Islander	2.1
Southeast Asian	2.9
Filipino	0.9
Other/Unknown	4.8

Table 9, which presents expenditures for fiscal year 1996-97, reveals the vast undertaking of providing public mental health services in this State. Over $1.7 billion was spent in fiscal year 1996-97 providing public mental health services. Approximately $450 million was spent for children, and $1.25 billion was spent for adults. Most of these funds, $1.6 billion, are spent by county mental health programs providing mental health services in their communities.

Table 9: Expenditures in the Public Mental Health System for Fiscal Year 1996-97 (in millions)[4]

Services	Children	Adults	Total
Community Mental Health (includes Acute Inpatient)	$438.8	$1,151.1	$1,589.9
State Hospitals (Civil Commitments Only)		99.9	113.1
Total	$452.0	$1,252.0	$1,702.0

EVOLUTION OF OVERSIGHT OF THE PUBLIC MENTAL HEALTH SYSTEM

Because of the magnitude of public expenditure, the serious nature of the mental illnesses, and the need of mental health clients for on-going treatment and rehabilitation, the State Legislature, at the urging of the mental health advocates and providers of services, adopted a requirement that county mental health programs must collect and report to the Department of Mental Health (DMH) data on the performance of their mental health systems.

In 1991, the Legislature enacted a statute that realigned the funding and program responsibility for mental health services. Previously, the mental health system had been funded from general tax revenues. Because mental health services were not an entitlement, they fared poorly in the State's annual budget process. During the 1980's, the mental health system experienced serious erosion of its funding by not being able to keep up with inflation. It even experienced reductions in state funding during that period. Because of the system's serious fiscal problems, the mental health community was open to changing the funding strategy. The realignment legislation replaced the General Fund revenues with one-quarter cent of the Sales Tax, which was dedicated to county mental health services.

Because sales tax revenues are considered a local revenue source, this funding arrangement dramatically changed the governance of the public mental health system. Prior to realignment, the system had been centralized under the control of the DMH, which allocated funds to county mental health programs and directed the types of services to be provided. After realignment, the DMH's role was more one of providing technical assistance to local programs, managing the state hospitals, and administering the State's Medi-Cal program funding mental health services.

During the development of the realignment legislation, mental health advocates were concerned about the loss of centralized authority over the county mental health program. Realignment gave counties greater autonomy to design their own service systems and greater flexibility in how they spent the funds. Advocates wanted to

[4] These expenditures exclude the cost of services provided to patients who are judicially committed to state hospitals

ensure that a system was in place that held counties accountable for results of their management of local programs. As a result, the realignment legislation included a requirement that county mental health programs had to collect and report to the State performance outcome data on their clients.

Several years after the enactment of realignment and its performance outcome measure requirements, the DMH initiated a major system change: consolidating the Fee-for-Service Medi-Cal system with the Short-Doyle Medi-Cal system and moving the entire Medi-Cal mental health system to managed care. Chapter 6 on Managed Mental Health Care describes the evolution of this system. The managed care initiative necessitated that the DMH rethink its approach to oversight of the public mental health system. It issued a series of papers on oversight (California Department of Mental Health, 1998c); (California Department of Mental Health, 1998b).

Requirement To Collect Performance Outcome Data

In the realignment legislation, the DMH was given the responsibility to establish a committee that would specify the outcome measures. In subsequent legislation, the California Mental Health Planning Council (CMHPC) was given the authority to review and approve all outcome measures and to use the data to review program performance annually. Additionally, the CMHPC is supposed to use the data to identify best practices in providing mental health services so that those services can be replicated in other counties. These statutory provisions are found in the Welfare and Institutions Code (WIC), Section 5772(c).

Mental health boards and commissions (MHBCs) are also given a role in the interpretation of their counties' performance outcome data. WIC Section 5604.2(a)(7) requires that MHBCs review and comment on the performance outcome data and communicate their findings to the CMHPC. The CMHPC developed a workbook format to facilitate this reporting process by MHBCs. Each MHBC received a workbook with that county's performance outcome data. The data were accompanied by a series of questions to assist the MHBC members in interpreting the results for each indicator. The workbook also contained additional demographic and socioeconomic data to assist the MHBCs in understanding the local context for its county's results. MHBCs were encouraged to collaborate with the local mental health program to complete the workbook. Once the CMHPC received all the workbooks, it prepared a statewide report, which by statute was distributed to the Legislature, the DMH, county governing bodies, and MHBCs. The CMHPC anticipates using a similar procedure with future performance outcome data.

The system to collect performance outcome data has evolved into a massive undertaking. Data are to be collected annually for all clients who receive services for more than 60 days. Table 1 shows that approximately 25,000 children and 185,000 adults and older adults fall into that category. This requirement was essentially created through the political process for developing legislation. Its implementation has been overseen by a collaboration of representatives from the CMHPC, the DMH, and county mental health programs. Implementation decisions have been guided by what the CMHPC believes is necessary for it to provide oversight of the system tempered by the need to have an administratively workable system that was not too burdensome on county mental health programs.

Theoretical Perspective on Use of Performance Indicators for Quality Assessment

Nature of Performance Indicators

Performance indicators are evaluative criteria (Sofaer, 1995). A set of indicators represents an explicit statement of expectation for the health care delivery system. Performance indicators are intended to provide useful information relevant to whether their expectations are being met. Donabedian (1980) identified three types of performance indicators: structure, process, and outcome. Structure relates to the prerequisites to providing services in systems of care, which include the administrative structure, fiscal organization, organization of programs, and interagency collaboration. Structure can often be evaluated by assessing compliance with specific requirements to operate the program (California Department of Mental Health, 1998c).

Process is the proper provision of services in systems of care. Process indicators include utilization of various types of services. Process is often evaluated through assessment of access and adherence to standards (California Department of Mental Health, 1998c). The third type of performance indicator is outcome. Outcome is the impact of care on health and well being, the ultimate goals of providing services. These goals include improvement or stabilization in a client's symptoms and functioning and in client satisfaction with quality of life, health status, and community integration (California Department of Mental Health, 1998c).

DRAFT

The DMH's oversight paper adopts the triad of performance indicators: structure, process, and outcomes. However, other researchers working on oversight of the public mental health system further subdivide process into access, appropriateness, and cost-effectiveness indicators. Access is the availability of culturally competent services to persons who need them in a manner that facilitates their use. Access includes the degree to which services are quickly and readily obtainable. It also relates to the availability of a wide array of relevant services to meet individual needs (Task Force on a Consumer-Oriented Mental Health Report Card, 1996).

Appropriate services are those that are individualized to address a consumer's strengths and weaknesses, cultural context, service preferences, and recovery goals. Appropriateness of care refers to the best possible match between client's needs and (a) level of care, e.g., inpatient or outpatient, and setting, e.g., psychiatric ward, office, home; (b) the chosen treatment or intervention, e.g., medication or therapy; and (c) service utilization, e.g., length of stay, number of outpatient sessions, and appropriate transitions. Standards for assessing appropriateness are based on the best available efficacy, effectiveness, appropriateness, and quality of care research (Salzer, 1997).

Cost effectiveness is the ability to use resources efficiently to achieve positive outcomes. An example would be using crisis stabilization or crisis residential services instead of acute inpatient hospitalization, if appropriate to a client's needs.

Recommendation: The CMHPC recommends that the following taxonomy be used in classifying the performance indicators for oversight of the public mental health system:

1. Structure
2. Process
    a. Access
    b. Appropriateness
    c. Cost-effectiveness
3. Outcomes

Definitions

One of the issues that the DMH highlighted in its first paper on oversight of the public mental health system was the need for consistent terminology when discussing performance outcome issues:

> …terminology has been and continues to be a major stumbling block in discussions of oversight. It is the practice in both the private and public sectors to use terms like "indicator," "outcome," and "standard" routinely, and yet specific meanings vary according to the context in which each is used. A common language needs to be developed to facilitate communication of principles and practice regarding oversight (California Department of Mental Health, 1998c).

The American College of Mental Health Administration (ACMHA), a national organization of mental health clinicians and administrators, has undertaken a project to develop a proposed set of performance indicators that can be used by both public and private behavioral health care providers. As a part of this project, it has developed a taxonomy of terms related to performance indicators:

- Domain: the most global term, which would be at the level of structure, process, access, appropriateness, cost effectiveness, and outcome.
- Concern: the most salient issue to be addressed by measurement strategies; describes the desired goal of service provision; e.g., "Clients can access services that they need" states a "concern."
- Indicator: something being measured
- Measure: the mechanism or data element identified to support a judgement or an indicator.

Characteristics of Valid Performance Indicator Sets

The process for developing and adopting performance indicators must have normative validity (Sofaer, 1995). When performance indicators have normative validity, all stakeholders would agree that the indicators reflect

their shared values about the ideal nature of the mental health system. Selection of performance indicators is inherently value-laden. Different constituency groups bring different norms, values, and priorities to bear on the inclusion of particular indicators and the construction of indicator sets. The statutory role given to the CMHPC to approve performance outcome measures assures normative validity because its membership includes all key stakeholders:

- direct consumers;
- family members;
- advocates;
- local mental health directors;
- community agencies;
- mental health professionals; and
- state agencies, including the DMH.

A performance indicator must be an effective proxy for critical aspects of provider, health plan, or health care system functioning (Sofaer, 1995). Performance indicators operationalize evaluative criteria. Each indicator should be a valid and reliable measure that is both sensitive and specific. Indicators should be also effective in distinguishing high and low performers.

Selected indicators should carry a great deal of information on important issues. Indicators should be chosen not only because they measure attributes that are important in themselves but also because these attributes correlate highly with other important characteristics. Identifying good proxies for system performance requires understanding the relationships between and among health care structures, process, and outcomes. A good performance indicator should be backed by empirical evidence of these relationships.

Performance indicators should also possess criterion-related validity (Salzer, 1997). Criterion-related validity is "the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 1991, page 1). Criterion-related validity pertains to the extent that structure and process indicators are linked with outcome and outcome indicators are linked to structure and process.

Inferences about the validity of a performance indicator can be drawn from the types of evidence listed below. Stronger inferences can be drawn from methods at the head of the list; weaker inferences from those methods near the end of the list:

- meta-analyses;
- randomized clinical trials;
- nonrandomized clinical trails;
- expert panel judgement; and
- individual practitioner judgement.

The majority of indicators in contemporary efforts to develop indicator sets are based on expert opinion. Salzer (1997) explains that indicators based on expert opinion have normative validity:

> …normative and consensual validity are weak forms of evidence for making conclusions about criterion-related validity…. This is a reasonable place to begin given the current dismal state of quality of care research, but it must be emphasized that these are unvalidated indicators. Care must be used when discussing results using indicators based on weak forms of inferential evidence (p. 299).

Performance indicators can be referred to as valid when the link between structure, process, and outcome has been established. This approach holds service providers accountable for developing quality service structures and processes that can be expected to produce positive outcomes. This approach is more appropriate than holding service providers responsible for poor outcomes that may have resulted despite high-quality service delivery. The value of a proposed structure or process indicator as a measure of quality is determined by the extent to which it is related to some outcome (Salzer, 1997). For example, coordination of services, a structural variable, may be found to be associated significantly with decreased symptoms and increased functioning. Coordination of services would then be viewed as a valid indicator of decreased symptoms and increased functioning.

DRAFT

Figure 2 illustrates the relationships between indicators of structure and process and those of outcome. Salzer's point is that the causal relationships between aspects of the service system and outcomes must be established in order to consider indicators that measure characteristics of the service system to be valid indicators of quality. Similarly, outcomes that are not a result of the delivery of mental health care cannot be considered valid performance indicators.

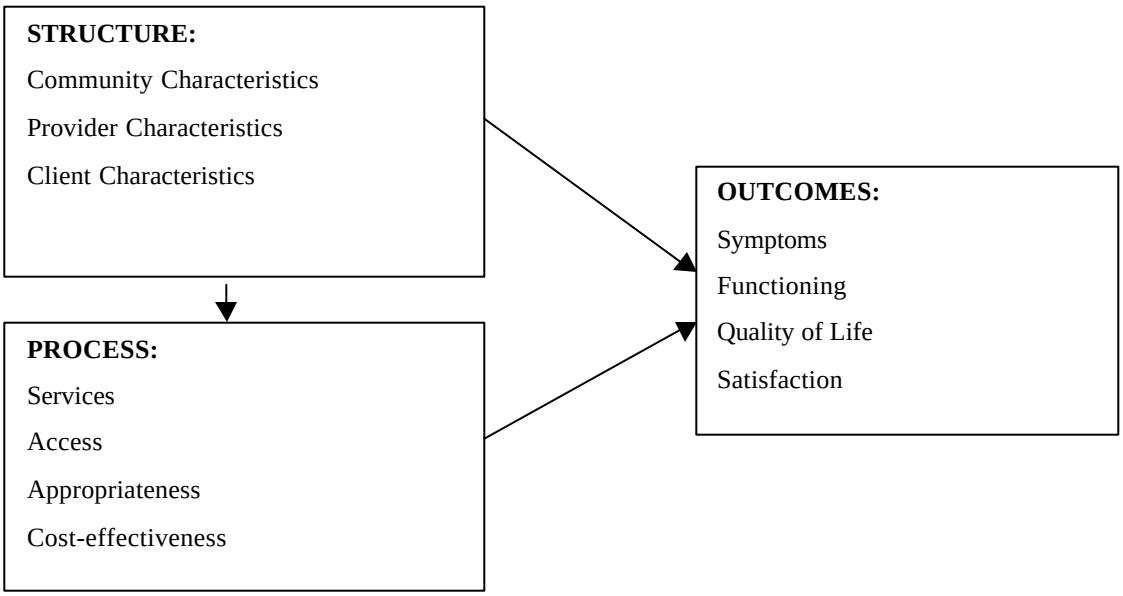

Figure 2: Model of Relationships among Performance Indicators

Theoretically, all the elements in the structure and process parts of the model can affect outcomes. For example, variables related to structure could include the county's unemployment rate, the amount of mental health funding per capita, and the case mix of clients served as measured by severity of their mental illness. Each of these factors can influence both the process of providing services and the outcomes. A county with higher per capita funding will be able to offer a more complete array of mental health services and more units of service. An outcome, such as the rate of employment of clients, will be affected by the unemployment in the county. Counties with adverse economic conditions are going to have a harder time placing clients in paid employment than a county with many job opportunities. A client's level of functioning is also going to determine the extent to which he or she can participate in paid employment. This basic example with one performance indicator, rate of client employment, illustrates the complex set of factors that contributes to producing an outcome.

The Appendix to this chapter contains an example of indicator sets for each target population. Indicators are included for each type of indicator discussed in the theoretical model: structure, process (access, appropriateness, cost-effectiveness), and outcomes.

NEED FOR AN INTEGRATED DATA SET FOR OVERSIGHT

An integrated data set is needed to validate the relationships among the structure, process, and outcome indicators and to evaluate the performance of local mental health programs. "Integrated data sets" refers to the ability to link a variety of information about clients across the DMH's separate data systems. The following data systems are available for system oversight:

- Client and Services Information System
- Cost Reporting/Data Collection System
- Performance Outcome Indicators
  - Children and Youth

DRAFT

  - Adult
  - Older Adult
- Children's System of Care data elements
- Medi-Cal Paid Claims
- Managed Care Implementation Plans
- Cultural Competency Plans
- Onsite Reviews

Chapter 738, Statutes of 1998, (SB 2098, Wright), required the DMH to develop unique client identifiers for its data systems. These identifiers will mean that demographic, service utilization, cost, and performance indicator data for each client can be linked across data sets. This capability will enable the DMH to conduct studies to determine the criterion-related validity of the performance indicators. Generally, data are available from the DMH's data system 6 to 12 months after the close of the fiscal year.

CONCEPT OF ACCOUNTABILITY

The main purpose for creating performance indicators was to facilitate oversight of county mental health programs by the DMH, the CMHPC, and local mental health boards and commissions. The intention was also that local mental health programs could monitor their own performance and use the data in their quality improvement processes.

Although performance indicators hold great promise in helping to improve the quality of mental health programs, users of the data must be mindful of their methodological limitations. Much work needs to be done before unambiguous conclusions can be drawn from performance indicators. For example, measurement error and confounding variables affect the kinds of outcomes counties can report. These factors have no relationship to the quality of the services provided. Some of these limitations in interpreting performance outcome data were identified in the first attempts to analyze the data in the early 1990's. For example, the first analyses of the adult performance outcome data, which were collected in fiscal year 1992-93, ranked counties from the best to the worst outcomes on various indicators. However, a cursory analysis revealed the flaw of that approach: some outcome measures are strongly influenced by local conditions. For example, counties with the lowest rate of employment for consumers also had the highest rates of unemployment for their general populations.

These data must be interpreted within their local context taking into account client characteristics, socio-economic conditions, and resources. Risk adjustment is the process for adjusting performance indicators so comparisons among counties can be made. Without such adjustments that take into account differences among counties, direct comparison of counties' results is not possible. Until techniques for risk adjustment are developed, the CMHPC needs to use a different approach for accountability. That approach is to hold counties accountable for their use of the data in their quality improvement processes. Counties can demonstrate their accountability by using performance indictor data in their quality improvement processes. Performance indicator results can be used for a variety of purposes:

- identifying gaps in the system of care;
- improving the quality of existing services; and
- identifying opportunities for great efficiency and more cost-effective services.

Recommendation: Because the performance indicators lack established criterion-related validity, risk adjustment to compensate for differences among counties, and benchmarks for minimum acceptable performance, the data must be used to describe the performance of the current system. System development should focus on the following actions:

- assure that the indicator set has face validity and normative validity;
- generate data for each county from existing data systems for the indicators, which will stimulate productive discussions about their implications related to the quality of the service system;
- use local quality improvement systems to explore the relationships between the indicators and to understand variables that influence quality; and
- encourage scientific studies to establish the criterion-based validity of the indicator set.

DRAFT

ROLE OF CMHPC IN SYSTEM OVERSIGHT

Section 5772 of the Welfare and Institutions Code (WIC) gives the CMHPC the authority to review, assess, and make recommendations regarding all components of California's mental health system. The statute makes frequent reference to the term, "performance outcome measure," in describing the CMHPC's mandate. The statute was developed in the early 1990's. Only in the last few years has the public sector integrated the increased theoretical sophistication of oversight and quality review from the behavioral health care industry and the research literature. The term, "performance outcome measure," has come to refer to one type of performance indicator that measures the results of receiving services on a client's health and well being. In using the term, "performance outcome measure," the authors of the legislation were referring to the broader class of indicators now understood to include structure and process indicators. Specifically, data recommended to be collected in WIC Section 5612 relates to both structure and process as the examples below illustrate:

- number of persons in identified target populations served relates to access;
- treatment plan development for members of the target population relates to appropriateness;
- percentage of resources used to serve children and older adults relates to access;
- number of patients' rights advocates and their duties relates to structure; and
- quality assurance activities relate to structure.

Recommendations:

1. In keeping with the intention of the statute, references in statute to "performance outcome measures" should be interpreted to mean "performance indicators." The CMHPC should assert its authority to approve all the performance indicators, not just the outcome indicators.
2. The CMHPC should continue to consult with the DMH on the development and implementation of current initiatives:
    a. managed care;
    b. performance outcome measures;
    c. the State Quality Improvement Committee; and
    d. the Compliance Advisory Committee.
3. The CMHPC should monitor the DMH oversight activities, including:
    a. assuring client and family member involvement in oversight activities;
    b. reviewing and commenting on various oversight protocols and procedures; and
    c. assuring that plans of correction from onsite reviews are followed up on.
4. The CMHPC should assist MHBCs with their oversight responsibilities, including:
    a. determining how to assure that MHBCs are involved in the local quality improvement system; and
    b. determining how to help MHBCs assess the adequacy of local quality improvement systems.
5. The CMHPC should ascertain whether local mental health programs are using available data for quality improvement.

PRINCIPLES TO GUIDE CONTINUED DEVELOPMENT OF OVERSIGHT AND USE OF DATA

The DMH, the CMHPC, and local mental health programs should adopt the following principles to guide development of oversight and the use of performance indicators:

1. Consumers and family members should be involved in development and implementation of oversight. This involvement can be ensured through the following means:
    - CMHPC representation on policy development committees;
    - continued involvement of the Client and Family Member Task Force; and
    - client and family member representation on on-site reviews.

2. To the extent possible, the oversight paradigm and performance indicators should be derived from accepted national models:

   - American College of Mental Health Administration; and
   - Mental Health Statistics Improvement Project Consumer Oriented Report Card.

3. All indicators should be derived from existing data. Very rich data sets have been created for the public mental health system. Stakeholders should master the use and interpretation of these data before developing additional requirements.

4. Performance indicators should provide data that are useful to the clinician in assessment and treatment planning and should enable the clinician to assess his or her own effectiveness.

5. When using the data, the DMH and the CMHPC should take an incremental approach to reporting the data. The goal of reporting results for performance indicators is to enable local mental health programs, mental health boards and commissions, and the CMHPC to understand the implications of the data analysis for system performance and improvement. Providing focused reports on aspects of performance rather than comprehensive reports on the entire system will likely result in better use of the data.

6. Different degrees of oversight are warranted for various populations being served. The amount of effort to evaluate services should be commensurate with the amount of resources spent providing services. For example, services to target populations should receive the most scrutiny. Services to brief and episodic users do not warrant as many resources for oversight.

7. To assure the cultural competency of oversight activities, the DMH should place high priority on developing proper translations of outcome instruments, obtaining sufficient back translations to produce valid instruments.

NEXT STEPS IN THE USE OF PERFORMANCE INDICATORS FOR SYSTEM OVERSIGHT

Risk Adjustment

Outcome indicators are influenced by many factors beyond the control of local mental health programs. The purpose of risk adjustment is to isolate the aspects of providing mental health services that are under the control of local mental health programs. To understand the performance of local mental health programs, the effects of those confounding variables beyond the control of mental health programs must be eliminated. This statistical process is referred to as risk adjustment. Examples of variables to be used for risk adjustment include client characteristics, socioeconomic conditions in each county, and fiscal resources available to fund mental health services. Risk adjustment should facilitate the identification of best practices in the provision of mental health services.

At this point, risk adjustment techniques are highly theoretical and experimental. However, the field of risk adjustment is becoming better defined. For example, payors in the private behavioral health care field are using risk adjustment in provider profiling. Some state governments are using risk-adjusted performance indicators to make decisions about whether to fund specific mental health providers. Key principles for selecting risk adjustment variables are being proposed (Boaz, 1999);(Hendryx, 1999):

- they should be prognostic indicators of disease course;
- they should be substantively related to the outcome;
- they should be outside the control of providers to effect through treatment;
- they should be able to be measured reliably and validly;
- they should account for variance in the outcome indicator (dependent variable); and
- they should not interact with the provider groups, i.e., the relationships between risk adjustment variables and dependent variables are consistent across the providers.

Once the correct risk adjustment variables have been selected for each performance indicator and their effects on the indicators thoroughly analyzed, the data for each county should be adjusted to the statewide average for the risk adjustment variable under consideration. As risk adjustment analyses become more sophisticated,

multivariate risk adjustment techniques should be used so that performance indicators can be adjusted simultaneously for more than one variable.

Recommendations: The DMH, CMHPC, and California Mental Health Directors Association (CMHDA) need to begin the process of developing risk-adjustment techniques so that the performance of local mental health programs can be compared to the statewide and regional averages.

1. A thorough literature review needs to be conducted to identify the independent variables besides mental health treatment that can affect each performance indicator.
2. The State's data bases need to be evaluated to determine whether they contain data on the relevant risk adjustment variables.
3. Data analyses need to be conducted to select the best risk adjustment variables for each outcome measure.
4. County mental health programs need to be involved in the selection and testing of risk adjustment variables to ensure that all the relevant factors that affect their performance are taken into account.
5. Once the risk adjustment variables have been selected and evaluated, each county's outcome data for each indicator need to be risk adjusted to the statewide average to facilitate comparisons with the statewide average and regional averages.

Decision Rules for Evaluating Performance

Risk adjustment is designed to eliminate differences among counties that cannot be attributed to delivery of mental health services. Once that step has been completed, the next logical step is to develop decision rules to identify high and low performers (Kamis-Gould, 1996). Comparing results of counties on an indicator to determine which is higher and which is lower is relatively easy. However, whether demonstrated variance means high performance or only a minor difference is not as self-evident. Because behaviors and performance levels vary and fluctuate over time, existing data must be analyzed to decide whether high levels will be determined by quartiles, percentiles, or better yet, standard deviations above and below the mean.

This approach for developing decision rules advocated by Kamis-Gould (1996) is consistent with the DMH's advocacy in its oversight white paper for "fenceposts" or "parameters" for indicators (California Department of Mental Health, 1998c). A multidimensional system of performance indicators requires decision rules that possess the following features:

- determination of high and low performance on any one indicator (e.g., in terms of standard deviations from the mean);
- determination of high and low performance on any one domain (e.g., at least two high performance indicators and no low one);
- a decision about whether stability over time should be built-in (i.e., whether some levels should be demonstrated more than once); and
- integration of levels across domains and determination of highs and lows on total performance.

Kamis-Gould (1996) provides the following example of decision rules used in New Jersey. New Jersey defines high performance as two standard deviations above the means on at least two performance indicators in at least two domains for two consecutive quarters and no low performance on any one domain. This standard is designed to exclude one-time spikes in performance and to keep highly efficient but ineffective providers from being considered high performers.

Recommendation: Once the DMH can reliably risk adjust the performance indicators, decision rules should be established to identify high and low performers.

DRAFT

APPENDIX

INDICATORS FOR SYSTEM OVERSIGHT FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES [5]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES [6]

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socio economic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate.	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for children age 0-17.	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population.	DOF Population Data
	Risk Adjust. 4: Severity of mental illness among client population age 0-17.	CAFAS or CBCL at intake

[5] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the children's system of care is in transition, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once new instruments are selected.

[6] These variables are being introduced for purposes of discussion only.

DRAFT

DOMAIN: STRUCTURE

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification.	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity.	County administration Cultural Competency Plans
	Structure 3: Percentage of staff who are bilingual by language.	County administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for children and families and provides continuity of care.	**Structure 4:** Under consideration.	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which children and families need to interact.	**Structure 5:** Under consideration.	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care.	**Structure 6:** The organization has a quality improvement system in place.	On-site reviews
	Structure 7: Counties are measuring children's performance outcomes and submitting the data to the DMH in a timely fashion.	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use.	**Structure 8:** Number of formal grievances filed by consumers.	Not collected

DRAFT

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Structure 9: Number of fair hearings filed by consumers.	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations.	**Access 1:** Percentage of county population age 0-17 who receive mental health services in one year by modes of service as defined by Client Services and Information System (CSIS), gender, ethnicity, and diagnosis.	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles age 0-17 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis.	Medi-Cal Paid Claims
Range of Service Options Available		
Concern: Children and families can access services that they need.	**Access 3:** Total units of service for each mode of service.	CSIS
	Access 4: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work).	CSIS & CR/DC
	Access 5: Percentage of respondents who report that services they need are readily available.	CSQ-8 Q2, 3
Cultural and Linguistic Access		
Concern: Children and families have access to a mental health provider who meets their needs in terms of ethnicity, language, and culture.	**Access 6:** Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language.	CSIS

DRAFT

DOMAIN: APPROPRIATENESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: Children using mental health services do so voluntarily and in collaboration with their families and service providers. The use of involuntary mental health intervention is minimized.	**Appro 1:** Percentage of admissions for psychiatric inpatient treatment that are involuntary.	CSIS
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care.	**Appro 2:** Percentage of children discharged from inpatient services that receive ambulatory services within 7 days.	CSIS
	Appro 3: Percentage of children in acute psychiatric inpatient care who have a visit from a case manager while in the hospital.	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: Children experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time.	**Appro 4:** Percentage of inpatient readmissions that occur within 30 days of discharge.	CSIS
Family and Youth Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: Families and youth using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.	**Appro 5:** Percentage of full-time equivalent staff positions that are occupied by family members of children who have received public mental health services.	Special Studies
	Appro 6: Percentage of youth on mental health boards and commissions and Quality Improvement Committees.	Special Studies
	Appro 7: Percentage of family members on mental health boards and commissions and Quality Improvement Committees.	Special Studies

DRAFT

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible.	**CE 1:** Proportion of total expenditures for services spent on placements in ♦ state hospitals ♦ group homes ♦ foster homes ♦ acute psychiatric hospitals	Various state data systems collected for system of care counties
	CE 2: Number of placements in ♦ state hospitals ♦ group homes ♦ foster homes	Various state data systems collected for system of care counties
	CE 3: Length of stay in state hospitals for children age 0-17.	Various state data systems collected for system of care counties
	CE 4: Number of bed days in acute psychiatric hospitals for children age 0-17	Various state data systems collected for system of care counties

DOMAIN: OUTCOMES

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Living Situation		
Concern: Children and adolescents who are seriously emotionally disturbed should remain in their homes whenever possible or should be placed in the least restrictive, most appropriate, natural environment as close to home as possible.	**Outcome 1:** Number of days in each placement during the year.	
	Outcome 2: Level of restrictiveness of each placement.	

DRAFT

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Concern: Children and adolescents who are seriously emotionally disturbed should be afforded maximum stability in their living situations, moving during the year as few times as possible consistent with their treatment needs.	**Outcome 3:** Number of places a child has lived during the year.	
	Outcome 4: Subjective satisfaction of children and families with the children's living situation.[7]	
Psychological Health		
Concern: The level of psychological distress from symptoms experienced by a child or adolescent is minimized.	**Outcome 5:** Percentage of children and adolescents who experience a reduction in psychological distress.	
Concern: The level of distress experienced by a family with children or adolescents with serious emotional disturbances is minimized.	**Outcome 6:** Percentage of children and adolescents whose families experience improved functioning or a reduction in family distress.	
Physical Health and Safety		
Concern: Children and adolescents who are seriously emotionally disturbed should have an individualized plan of coordinated care that anticipates and addresses their unique and multiple needs, including physical health and need for medication.	**Outcome 7:** Percentage of children and adolescents with serious emotional disturbances whose health is affected by collateral physical health problems who are receiving comprehensive services coordinated between their mental health care and physical health care provider.	

[7] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

DRAFT

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Outcome 8: For children and adolescents on psychiatric medication: ♦ clinician's evaluation of the effectiveness of the medication; ♦ clinician's evaluation of whether they have adequate access to the physician prescribing the medication; ♦ children's evaluation of whether the medication is making them feel better; and ♦ parent's evaluation of whether the medication is improving the children's psychological health.	
Concern: Children and adolescents who are seriously emotionally disturbed should feel safe in all aspects of their lives.	**Outcome 9:** Children and adolescents subjective assessment of whether they feel safe in the following environments:[8] ♦ at home; ♦ in school; and ♦ in the community.	
Social Involvement and Functioning		
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in developing or maintaining nurturing relationships with their families.	**Outcome 10:** Percentage of children and adolescents who have age-appropriate family relationships.	
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to maintain a social support system and engage in meaningful activities, including playing, sports, socializing with peers, and other recreational activities.	**Outcome 11:** Percentage of children and adolescents who have age-appropriate social relationships.	
	Outcome 12: Percentage of children and adolescents who have age-appropriate interests and activities.	

[8] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

DRAFT

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
School Involvement and Functioning			
Concern: Children and adolescents who are seriously emotionally disturbed belong in school so that they may benefit from their educational program and are encouraged to achieve their maximum educational potential.	**Outcome 13**	Percentage of children and adolescents who are attending school regularly according to: ♦ the child or adolescent; ♦ the parent; and ♦ the clinician.	
	Outcome 14:	Percentage of children and adolescents in special education.	
	Outcome 15:	Assessment of academic performance according to: ♦ the child or adolescent; ♦ the parent; and ♦ the clinician.	
	Outcome 16:	Subjective satisfaction of the child or adolescent with attending school.[9]	
Legal			
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to develop and maintain socially responsible behavior, avoid involvement with the juvenile justice system, and remain free of substance abuse and addiction.	**Outcome 17:**	Reduction in the percentage of children and adolescents who have a substance abuse problem.	
	Outcome 18:	Reduction in the percentage of children and adolescents involved in the juvenile justice system.	
	Outcome 19:	Reduction in the recidivism of children and adolescents involved in the juvenile justice system.	
	Outcome 20:	Reduction in the percentage of children and adolescents engaging in at-risk behaviors, including vandalism, property destruction, and physical assault.	

[9] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

DRAFT

INDICATORS AND MEASURES FOR SYSTEM OVERSIGHT FOR ADULTS WITH SERIOUS MENTAL ILLNESSES

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES [10]

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate.	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for clients age 18-59.	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population.	DOF Population Data
	Risk Adjust. 4: Severity of mental illness among client population age 18-59.	Global Assessment of Functioning (GAF) Score

DOMAIN: STRUCTURE

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels, skills, and training are appropriate for meeting the diverse needs of the individuals served, including linguistic and cultural competency.	**Structure 1:** Number of staff per 1,000 clients by personnel classification.	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity.	County administration Cultural Competency Plans
	Structure 3: Percentage of staff who are bilingual by language.	County administration Cultural Competency Plans

[10] These variables are being introduced for purposes of discussion only.

DRAFT

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for clients and provides continuity of care.	**Structure 4:** Under consideration.	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact.	**Structure 5:** Under consideration.	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitor the performance of its system of care.	**Structure 6:** The organization has a quality improvement system in place.	On-site reviews
	Structure 7: Counties are measuring adult performance outcomes and submitting the data to the DMH in a timely fashion.	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined, and procedures for resolution of complaints and grievances are in place and easy to use.	**Structure 8:** Number of formal grievances filed by consumers.	Not collected
	Structure 9: Number of fair hearings filed by consumers.	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations.	**Access 1:** Percentage of county population ages 18-59 who receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis.	CSIS

DRAFT

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles ages 18-59 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis.	Medi-Cal Paid Claims
Quick and Convenient Entry into Services		
Concern: Entry into mental health services is quick, easy, and convenient.	**Access 3:** Percentage of respondents who report that the location of services is convenient. [11]	MHSIP Consumer Survey Q4
	Access 4: Percentage of respondents who report that services are available at times that are convenient.	MHSIP Consumer Survey Q7
	Access 5: Percentage of respondents who report that mental health staff returned their calls within 24 hours.	MHSIP Consumer Survey Q6
Range of Service Options Available		
Concern: Clients can access services that they need.	**Access 6:** Total units of service for each mode of service.	CSIS
	Access 7: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work).	CSIS
	Access 8: Percentage of respondents who report that services they need are readily available.	MHSIP Consumer Survey Q5 & 8
Cultural and Linguistic Access		
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture.	**Access 9:** Percentage of respondents who report that staff are sensitive to their ethnicity culture reported by ethnicity and language.	MHSIP Consumer Survey Q13
	Access 10: Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language.	CSIS

[11] Positive response to the MHSIP Consumer Survey is operationalized as answering 4 (agree) or 5 (strongly agree).

DRAFT

DOMAIN: APPROPRIATENESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized.	**Appro 1:** Percentage of respondents who report actively participate in decisions concerning their treatment.	MHSIP Consumer Survey Q17 & 18
	Appro 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary.	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery.	**Appro 3:** Percentage of Medi-Cal clients for whom medication is prescribed who received prescriptions for: a. atypical antipsychotics b. newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Appro 4: Percentage of respondents who report receiving services that support recovery.	MHSIP Consumer Survey Q9 & 14
	Appro 5: Percentage of respondents who report being involved in self-help activities.	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care.	**Appro 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days.	CSIS
	Appro 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital.	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time.	**Appro 8:** Percentage of inpatient readmissions that occur within 30 days of discharge.	CSIS

DRAFT

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.	**Appro 9:** Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services.	Special Studies
	Appro 10: Percentage of mental health consumers on mental health boards and commissions and Quality Improvement Committees.	Special Studies
	Appro 11: Percentage of family members on mental health boards and commissions and Quality Improvement Committees.	Special Studies
Adequate Information to Make Informed Choices		
Concern: Service recipients receive information that enables them to make informed choices about their care.	**Appro 12:** Percentage of respondents who report receiving adequate information to make informed choices.	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible.	**CE 1:** Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services.	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Living Situation		
Concern: Persons with mental disabilities have the right to choice, privacy, and independence in their living situation.	**Outcome 1:** Percentage of consumers with serious mental illnesses living in their own house or apartment.	CSIS[12]

[12] This measure would be analyzed for clients for whom performance outcome data has been collected.

DRAFT

INDICATORS FOR ADULTS	MEASURES		DATA SOURCE
	Outcome 2:	Percentage of consumers who move to less restrictive settings	CSIS[11]
	Outcome 3:	Percentage of consumers who report being satisfied with their living situation reported by living situation.[13]	QOL 2a, b, c
	Outcome 4:	Mean satisfaction with living situation reported by living situation.	QOL 2a, b, c
Financial Status			
Concern: Persons with serious mental illnesses should have an adequate income.	**Outcome 5:**	Percentage of consumers who are receiving the benefits to which they are entitled.	County Universal Method of Determining Ability to Pay Systems
	Outcome 6:	Percentage of consumers who report having enough money for each of these necessities: ♦ food ♦ clothing ♦ housing ♦ transportation ♦ social activities	QOL 10
	Outcome 7:	Percentage of consumers who report being satisfied with their finances.	QOL 11a, b, c
	Outcome 8:	Mean satisfaction with finances.	QOL 11a, b, c
Productive Daily Activity			
Concern: Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 9:**	Percentage of clients with serious mental illnesses involved in competitive employment (part-time or full-time).	CSIS[11]
	Outcome 10:	Percentage of clients with serious mental illnesses involved in volunteer activity.	CSIS[11]
	Outcome 11:	Percentage of clients with serious mental illnesses involved in education.	CSIS[11]

[13] For all outcome indicators, satisfaction is operationalized as answering with categories 5 (mostly satisfied), 6 (pleased), or 7 (delighted) on the instrument.

DRAFT

INDICATORS FOR ADULTS		MEASURES		DATA SOURCE
Symptoms				
Concern:	The level of psychological distress from symptoms is minimized.	**Outcome 12:**	Percentage of consumers experiencing a decreased level of psychological distress.	GAF score, & MHSIP Q26
		Outcome 13:	Suicide rate among persons with serious mental illnesses.	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning				
Concern:	Service recipients experience increased independent functioning.	**Outcome 14:**	Percentage of consumers who report increased functioning.	MHSIP Q20-25
Physical Health				
Concern:	Mental health services recipients should have good health and equal access (relative to the general population) to effective general health care.	**Outcome 15:**	Percentage of Medi-Cal clients who receive mental health services during the year who also received physical health care services through Medi-Cal.	CSIS or Medi-Cal Paid Claims & DHS Medi-Cal Data
		Outcome 16:	Mean score on quality of health reported by consumers.	QOL 15
		Outcome 17:	Percentage of consumers who report being satisfied with their health.	QOL 16a, b, c
		Outcome 18:	Mean satisfaction with health.	QOL 16a, b, c
Substance Abuse				
Concern:	Clients experience minimal impairment from use of substances.	**Outcome 19:**	Rate of all adults receiving services who are identified with substance abuse problems.[14]	CSIS[15]
Avoiding Legal Problems				
Concern:	Clients should be assisted in their efforts to maintain socially responsible behavior.	**Outcome 20:**	Percentage of consumers who report being arrested in the last month.	QOL 13

[14] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[15] This measure would be analyzed for clients for whom performance outcome data has been collected.

DRAFT

INDICATORS FOR ADULTS		MEASURES		DATA SOURCE
Personal Safety				
Concern:	Persons with serious mental disabilities have a right to personal safety and freedom from exploitation.	**Outcome 21:**	Percentage of consumers who report being a victim of a violent crime in the past month.	QOL 12a
		Outcome 22:	Percentage of consumers who report being a victim of a non-violent crime in the past month.	QOL 12b
		Outcome 23:	Percentage of consumers who report being satisfied with their personal safety.	QOL 14a, b, c
		Outcome 24:	Mean satisfaction with personal safety.	QOL 14a, b, c
Social Support Networks				
Concern:	Service recipients experience increased natural supports and social integration.	**Outcome 25:**	Percentage of consumers who experience increased activities with family.	QOL 4, 5
		Outcome 26:	Percentage of consumers who report being satisfied with their family contact.	QOL 6a, b
		Outcome 27:	Mean satisfaction with family contact.	QOL 6a, b
		Outcome 28:	Percentage of consumers who experience increased activities with friends, neighbors, or social groups.	QOL 7a, b, c, d
		Outcome 29:	Percentage of consumers who report being satisfied with their social relations.	QOL 8a, b, c, d
		Outcome 30:	Mean satisfaction with social relations.	QOL 8a, b, c, d

DRAFT

INDICATORS FOR SYSTEM OVERSIGHT FOR OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES [16]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES [17]

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Differences among counties			
Concern: Differences among counties in resources, socio economic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:**	County poverty rate.	Statistical Abstract
	Risk Adjust. 2:	Per capita funding for mental health services for ages 60 and older.	DMH and County Fiscal Systems
	Risk Adjust. 3:	Degree of ethnic diversity in county population.	DOF Population Data
	Risk Adjust. 4:	Severity of mental illness among client population for ages. 60 and older.	

DOMAIN: STRUCTURE

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Staffing			
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:**	Number of staff per 1,000 clients by personnel classification.	County administration
	Structure 2:	Percentage of staff who are bicultural by ethnicity.	County administration Cultural Competency Plans

[16] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the older adult system of care is under development, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once instruments are selected.

[17] These variables are being introduced for purposes of discussion only.

DRAFT

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
	Structure 3: Percentage of staff who are bilingual by language.	County administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for consumers and provides continuity of care.	**Structure 4:** Under consideration.	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact.	**Structure 5:** Under consideration.	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care.	**Structure 6:** The organization has a quality improvement system in place.	On-site reviews
	Structure 7: Counties are measuring older adult performance outcomes and submitting the data to the DMH in a timely fashion.	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use.	**Structure 8:** Number of formal grievances filed by consumers.	Not collected
	Structure 9: Number of fair hearings filed by consumers.	DMH Ombudsman Office

DRAFT

DOMAIN: ACCESS

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Services Are Reaching the Intended Population			
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations.	**Access 1:**	Percentage of county population ages 60 and older who receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis.	CSIS
	Access 2:	Percentage of the county's monthly average Medi-Cal eligibles ages 60 and older who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis.	Medi-Cal Paid Claims
Quick and Convenient Entry into Services			
Concern: Entry into mental health services is quick, easy, and convenient.	**Access 3:**	Percentage of respondents for whom the location of services is convenient.	MHSIP Consumer Survey Q4
	Access 4:	Percentage of respondents for whom services are available at times that are convenient.	MHSIP Consumer Survey Q7
	Access 5:	Percentage of respondents who report that mental health staff returned their calls within 24 hours.	MHSIP Consumer Survey Q6
Range of Service Options			
Concern: Clients can access services that they need	**Access 6:**	Total units of service for each mode of service.	CSIS
	Access 7:	Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work).	CSIS
	Access 8:	Percentage of respondents who report that services they need are readily available.	MHSIP Consumer Survey Q5 & 8
Cultural and Linguistic Access			
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture.	**Access 9:**	Percentage of respondents who report that staff are sensitive to their ethnicity and culture reported by ethnicity and language.	MHSIP Consumer Survey Q13
	Access 10:	Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language.	CSIS

DRAFT

DOMAIN: APPROPRIATENESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized.	**Appro 1:** Percentage of respondents who report actively participating in decisions concerning their treatment.	MHSIP Consumer Survey Q17 & 18
	Appro 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary.	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery.	**Appro 3:** Percentage of Medi-Cal clients for whom medication is prescribed who received prescriptions for: a. atypical antipsychotics b. newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Appro 4: Percentage of respondents who report receiving services that support recovery.	MHSIP Consumer Survey Q9 & 14
	Appro 5: Percentage of respondents who report being involved in self-help activities.	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care.	**Appro 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days.	CSIS
	Appro 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital.	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time.	**Appro 8:** Percentage of inpatient readmissions that occur within 30 days of discharge.	CSIS

DRAFT

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery.	**Appro 9:** Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services age 60 and over.	Special Studies
	Appro 10: Percentage of mental health consumers age 60 and over on mental health boards and commissions and Quality Improvement Committees.	Special Studies
	Appro 11: Percentage of family members on mental health boards and commissions and Quality Improvement Committees.	Special Studies
Adequate Information to Make Informed Choices		
Concern: Service recipients receive information that enables them to make informed choices about their care.	**Appro 12:** Percentage of respondents who receive adequate information to make informed choices.	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible.	**CE 1:** Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services.	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Physical Health		
Concern: Mental health services recipients should have equal access (relative to the general population) to effective general health care.	**Outcome 1:** Percent of Medi-Cal clients age 60 and older who receive mental health services during the year that also received physical health care services through Medi-Cal.	CSIS & DHS Medi-Cal Data

DRAFT

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
	Outcome 2:	Mean score on quality of health reported by consumers.	
	Outcome 3:	Percentage of consumers who report being satisfied with their health.	
	Outcome 4:	Mean satisfaction with health.	
Symptoms			
Concern: The level of psychological distress from symptoms is minimized.	**Outcome 5:**	Percentage of consumers who experience a decreased level of psychological distress.	GAF score, & MHSIP Q26
	Outcome 6:	Suicide rate among persons with serious mental illnesses.	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning			
Concern: Service recipients experience increased independent functioning.	**Outcome 7:**	Percentage of consumers who report increased functioning.	MHSIP Q20-25
Substance Abuse			
Concern: Clients experience minimal impairment from use of substances.	**Outcome 8:**	Rate of all adults receiving services who are identified with substance abuse problems.[18]	CSIS[19]
Productive Daily Activity			
Concern: Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 9:**	Proportion of older adults with serious mental illnesses involved in competitive employment.	CSIS[18]
	Outcome 10:	Proportion of older adults with serious mental illnesses involved in volunteer activity.	CSIS[18]

[18] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[19] This data would be analyzed for clients for whom performance outcome data has been collected.

DRAFT

INDICATORS FOR OLDER ADULTS		MEASURES		DATA SOURCE
Capacity for Independent Community Living				
Concern:	Clients function in community settings with optimal independence from formal service systems.	**Outcome 11:**	Percentage of older adults with serious mental illnesses living in their own home or apartment**.**	CSIS[20]
Concern:	Service recipients experience increased independent functioning.	**Outcome 12:**	Percentage of consumers who experience increased functioning.	
Social Support Network				
Concern:	Service recipients experience increased natural supports and social integration.	**Outcome 13:**	Percentage of consumers who experience increased activities with family, friends, neighbors, or social groups.	

[20] This data would be analyzed for clients for whom performance outcome data has been collected.